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An Independent Review Organization

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Notice of Independent Review Decision

Review Outcome:

A description of the qualifications for each physician or other health care provider who reviewed the decision:

Neurosurgeon

Description of the service or services in dispute:

Anterior lumbar interbody fusion at L4-5 and L5-S1 with 2 day LOS

Upon Independent review, the reviewer finds that the previous adverse determination / adverse determinations should be:

- ☒ Upheld (Agree)
- ☐ Overturned (Disagree)
- ☐ Partially Overturned (Agree in part / Disagree in part)

Patient Clinical History (Summary)

This patient is a xx year old individual. On 04/18/11, he was seen at. Muscle testing in the lower extremity revealed 4+/5 strength on the left. On 10/16/14, an MRI of the lumbar spine revealed surgical changes of a right laminotomy at L4-5. There was a right paracentral annular tear/disc bulge encroaching upon the right anterolateral recess and contacting the descending right L5 nerve root. Post-contrast images revealed mild enhancing granulation tissue in the right anterolateral recess as well. Surgical changes of the left laminotomy were identified at L5-S1. There was no evidence of recurrent disc or canal stenosis identified. There was a left paracentral/lateral osteophyte and facet arthrosis encroaching upon the left anterolateral recess and left neuroforamen. Osteophyte and facet arthrosis contacted the descending left S1 nerve root and approximated the exiting left L5 nerve root. Post-contrast images revealed no evidence of a recurrent herniated disc at that level. On 01/02/15, the patient was seen in clinic. Physical examination at that time revealed decreased strength in the right lower extremity with quadriceps, anterior tibialis, and extensor hallucis, and gastrocnemius strength all rated at 4/5. Sensation was decreased in an L5 distribution and Achilles reflex was 1+ with quadriceps reflex 2+. Left lower extremity strength revealed anterior tibialis strength at 3, quadriceps strength at 4, and extensor hallucis strength 4. Gastrocnemius strength was 3. Sensation was decreased in an L5 and S1 dermatome. Reflexes were 1+ at the Achilles and 2+ at the quadriceps. On 01/12/15, the patient was seen in clinic and had 4/5 strength of the EHL muscles bilaterally, and gastroc and biceps femoris muscles on the left otherwise strength was preserved. Deep tendon reflexes were 1+ at the ankle jerk on the left otherwise 2+ throughout and symmetrical. There was a hypoesthetic region over the L5 distribution bilaterally left greater than right. On 02/11/15, the patient was seen for pre-surgical evaluation from a psychological perspective, and it was indicated he was an appropriate candidate for the fusion procedure.

Analysis and Explanation of the Decision include Clinical Basis, Findings and Conclusions used to support the decision.

On 02/25/15, a review determination noted the requested procedure an anterior lumbar interbody fusion at L4-5 and L5-S1 with posterior lumbar decompression with posterolateral fusion and pedicle screw instrumentation at both L4-5 and L5-S1 with a 2 day length of stay was not medically necessary. The rationale given included notation that even though the provider stated the patient had a mobile retrolisthesis at L4-5 and a listhesis at L5-S1, the formal report of flexion and extension views showed no abnormal motion. There was a lack of spondylolisthesis or instability. A peer review occurred noting that there was 2 or 3mm mobile retrolisthesis at L4-5, and a 2nd opinion radiology reading of the flexion and extension views was discussed. On 03/11/15, an adverse determination was submitted for the same request, noting that the laminectomy was not indicated because there was no MRI documenting nerve compression which correlated with the patient's history or exam. It was noted the patient had left lower extremity pain and there was no left sided compression lesion to explain his pain. The fusion was not indicated because based on the radiologist's MRI and x-ray reports there was no instability, fractures, tumor, PARS defects that would require a fusion. It was noted there was a notation of a spondylolisthesis and this should be correlated with imaging studies prior to the procedure being performed.

For this review, x-rays obtained on 04/14/14, revealed no significant change in degenerative disc and facet disease at L2-3, L3-4, L4-5, and L5-S1. No abnormal movement was appreciated on bending views and there is no PARS defect. On 04/01/13, x-rays of the lumbar spine revealed no abnormal movement on bending views and no PARS defect. The records indicate the patient has only had 1 previous procedure at the surgical levels. Therefore, the records do not document instability or a PARS defect to require a fusion procedure. Additionally, while the records discuss conservative care, only 1 physical therapy note in 2011 was provided for this review. While there is documentation that the patient has neurological deficits, with the most recent physical examination documenting 4/5 EHL strength and gastroc and biceps femoris strength on the left, with decreased ankle jerk on the left, and a hypoesthetic region over the L5 distribution bilaterally left greater than right, the most recent MRI reveals a left laminotomy defect at L5-S1 with no evidence of a recurrent herniated disc or canal stenosis. There is approximation of the exiting left L5 nerve root, and there is contact of the descending left S1 nerve root. At L4-5, there are changes of a right laminotomy defect and there is mild enhancing granulation tissue in the right anterolateral recess. There is encroachment upon the right anterolateral recess and contact of the descending right L5 nerve root. Thus, the records do not indicate a rationale for a fusion versus a lesser procedure for both levels. Therefore, it is the opinion of this reviewer that the request for an anterior lumbar interbody fusion at L4-5 and L5-S1 with a 2 day length of stay is not medically necessary and the prior denials are upheld.

A description and the source of the screening criteria or other clinical basis used to make the decision:

- ☐ ACOEM-America College of Occupational and Environmental Medicine um
- ☐ knowledgebase AHCPR-Agency for Healthcare Research and Quality Guidelines
- ☐ DWC-Division of Workers Compensation Policies and
- ☐ Guidelines European Guidelines for Management of Chronic
- ☐ Low Back Pain Interqual Criteria
- ☒ Medical Judgment, Clinical Experience, and expertise in accordance with accepted medical
- ☐ standards Mercy Center Consensus Conference Guidelines
- ☐ Milliman Care Guidelines
- ☒ ODG-Official Disability Guidelines and Treatment
- ☐ Guidelines Pressley Reed, the Medical Disability Advisor
- ☐ Texas Guidelines for Chiropractic Quality Assurance and Practice
- ☐ Parameters Texas TACADA Guidelines
- ☐ TMF Screening Criteria Manual
- ☐ Peer Reviewed Nationally Accepted Médical Literature (Provide a description)
- ☐ Other evidence based, scientifically valid, outcome focused guidelines (Provide a description)